ITEM: 6

MEETING: Trust Board – 21 November 2007

TITLE: 18 week Referral to Treatment Update

SUMMARY:
This paper updates the Board on progress the Trust is making towards delivering the 18-week Referral to Treatment Target (RTT), providing an update the project planning process and performance to date. In addition an update is provided on the following key work streams: Improving data collection and validation, review of key policies, demand and capacity modelling, and productivity improvement planning.

ACTION: For Information

REPORT FROM: Kate Slemeck, Director of Operations

SPONSORED BY: David Sloman, Chief Executive Officer

Financial Validation Lead: Director of Finance	Tim Jaggard, Assistant Director of Finance
Compliance with statute, directions, policy, guidance Lead: All directors	
Compliance with Healthcare Commission Core/Developmental Standards Lead: Director of Nursing & Clinical Development	**Reference:** Yes
Compliance with Auditors' Local Evaluation standards (ALE) Lead: Director of Finance	**Reference:**
Compliance with requirements of FT application and monitoring regime Lead: Director of Strategy & Performance	**Reference:**

1. Getting to 18 weeks

Executive Summary

The 18 week project team has consolidated the various workstreams associated with the project into a single project reporting matrix, the 'performance report' associated with this is at appendix 1. This report is broken down into workstream areas. Each workstream has an associated written plan that has been or is being developed by the responsible officers listed.

Progress being made towards the 18 week Referral to Treatment Target action plan, including the alteration of key trust policies, and issues requiring clinical support were presented to the Hospital Management Board in November, and this report provides an update to those discussions.

1.1 Trust Performance Against 18 Week Trajectory

1.1.1 Performance Summary

18-week RTT performance is measured using two indicators:

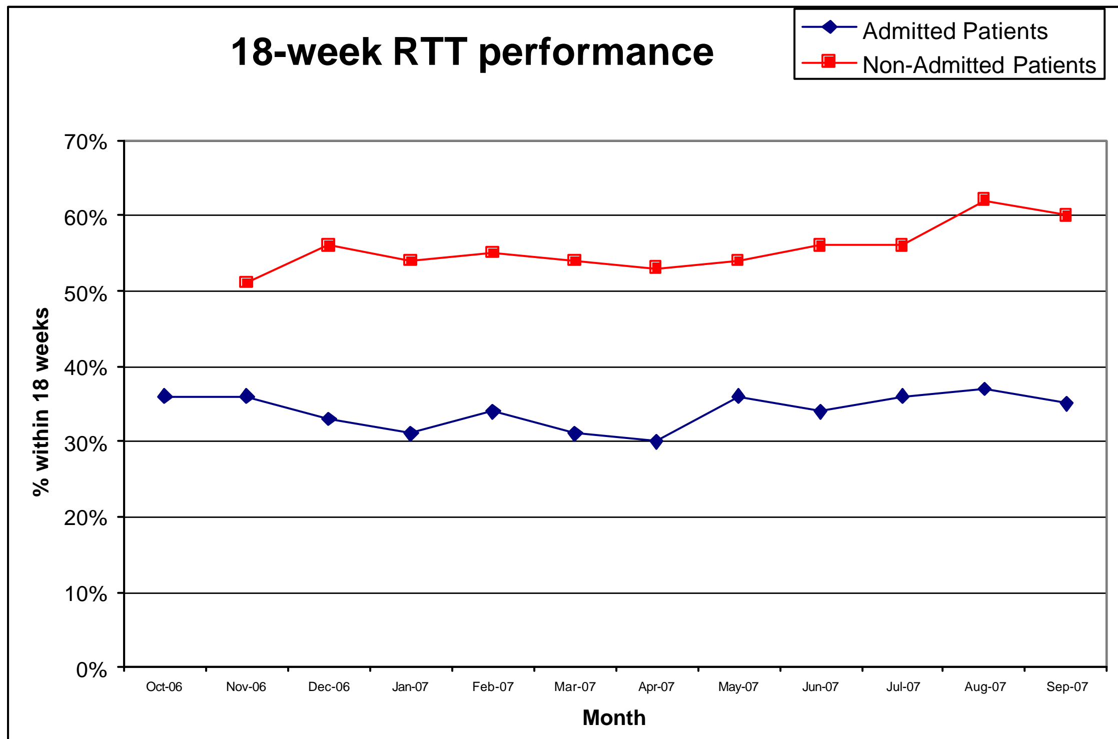
Admitted Patients — The national target for March 2008 is **85%**

Non-Admitted Patients — The national target for March 2008 is **90%**

The data below show the Trust position as reported to the Department of Health each since the start of monitoring.

Month	Admitted Patients	Non-Admitted Patients
Oct-06	36%	
Nov-06	36%	51%
Dec-06	33%	56%
Jan-07	31%	54%
Feb-07	34%	55%
Mar-07	31%	54%
Apr-07	30%	53%
May-07	36%	54%
Jun-07	34%	56%
Jul-07	36%	56%
Aug-07	37%	62%
Sep-07	**35%**	**60%**

Performance **for Admitted Patients** has remained around the mid thirties **(35%)** whilst improved data capture has maintained performance **for Non-Admitted Patients at 60%**. Significant improvements around admitted patients are unlikely to be achieved until surgical waiting time backlog of 16 to 20 weeks is cleared, whereas increasing the amount of data captured and unknown data validation is likely to improve the non-admitted patient performance.



1.1.2 Trust Performance by Specialty

The tables below provide the 18-week performance by specialty during September.

Admitted Patients 18 week performance – September 2007

Specialty	Number of RTT recorded	% less than 18w	% over 18w
General Surgery	164	41%	59%
Urology	83	34%	66%
Trauma & Orthopaedics	124	21%	79%
ENT	12	50%	50%
Pain Management	26	15%	85%
Gastroenterology	87	40%	60%
Clinical Haematology	5	60%	40%
Dermatology	1	0%	100%
Chest Medicine	1	0%	100%
Nephrology	0	-	-
Medical Oncology	4	75%	25%
Rheumatology	3	0%	100%
Paediatrics	23	17%	83%
Gynaecology	121	45%	55%
Total	**654**	**35%**	**65%**

Non-Admitted Patients 18-week performance – September 2007

Specialty	Number of RTT recorded	% less than 18w	% over 18w
General Surgery	64	73%	27%
Urology	36	50%	50%
Trauma & Orthopaedics	261	69%	31%
ENT	40	72%	28%
Ophthalmology	20	70%	30%
Pain Management	11	73%	27%
General Medicine	14	79%	21%
Gastroenterology	23	48%	52%
Endocrinology	52	38%	62%
Clinical Haematology	28	57%	43%
Diabetes	230	46%	54%
Cardiology	27	89%	11%
Dermatology	204	72%	28%
Chest Medicine	47	72%	28%
Nephrology	35	37%	63%
Medical Oncology	5	40%	60%
Neurology	55	84%	16%
Rheumatology	40	75%	25%
Paediatrics	62	27%	73%
Care of Older People	5	0%	100%
Maternity	13	54%	46%
Gynaecology	117	49%	51%
Total	**1389**	**60%**	**40%**

It should be noted that purely diagnostic and follow-up / planned procedures are excluded from the admitted patient category which means that the number reported is significantly lower than the numbers reported for SLA purposes.

1.1.3 Data Collection and Validation

The Trust was targeting 98% data completeness by October and although GMs are reviewing returns by clinic code on a weekly basis performance has remained static at around 50%, increasing towards 60% by the end of October.

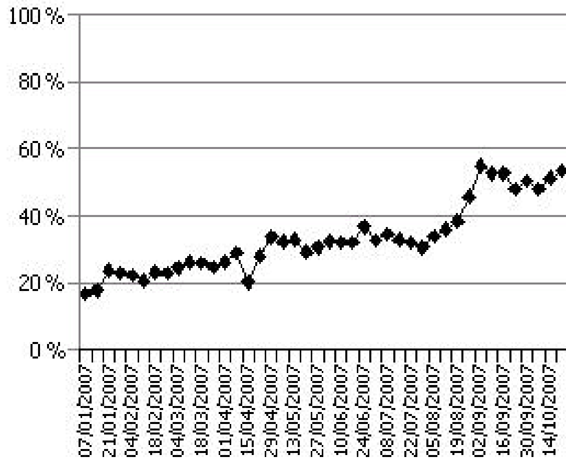
During the month revised outcome forms have been re-launched, and now include more information on DNAs as the completion rate of DNAs remains low. Performance is variable amongst specialities and clinician support in the accurate compilation of 18-week data via the outcome forms is an essential part of the 18 weeks project.

The most recent performance of outcome slip completeness for the trust as a whole and by Division is outlined below.

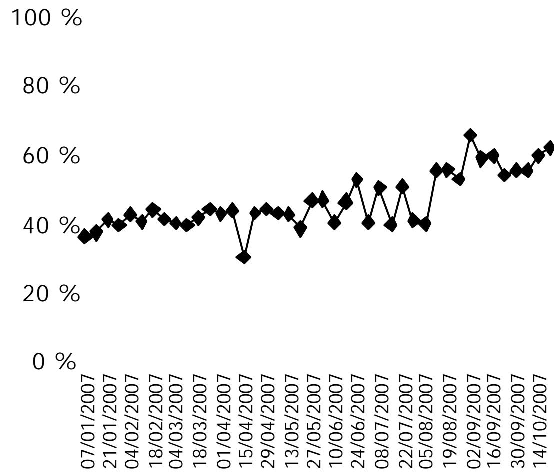
The validation of unknown and long waits is essential to improving trust 18-week target performance. Successful validation is likely to improve trust target performance for January 2008 as unknowns account for between 20 and 25% of all activity.

Pilot validation schemes in specific specialities will commence in November with all specialities being reviewed over the Christmas period.

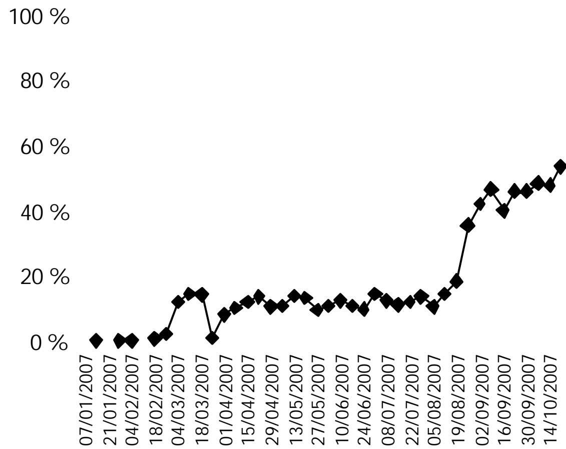
Trust



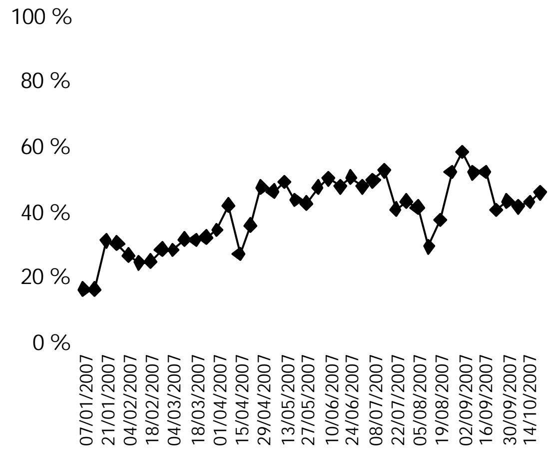
Medicine



Surgery



Women & Children



1.2. <u>Project Update</u>

1.2.1 Revised 18 Week Project Plan and Performance Report

The performance report against the project plan (appendix 1) illustrates progress to date on the various work streams, projected timescales, and responsibilities for delivering the 18-Week target.

The 18-week Working Group together with the General Managers has developed these work streams. In many cases these are new work streams. Each is designed to cover an aspect of work designed to move the project forward to the final quarter of 2007/8 and into the March 2008.

This Plan (October 2007 iteration) covers the period from October 2007 until March 2008. The next critical date is January 2008 by which many of the work streams will have been implemented and planning completed for January to March 2008.

Each workstream identified within the performance report has behind it a written project plan detailing key actions, timelines, and expected benefits. Each named lead responsible officer is completing these.

The work streams were developed from Project Task Lists / Actions Lists / Issues Log entries from divisional teams, best practice from other trusts and national 18-week guidance.

Workstreams were also developed from a benchmarking exercise against NHS London: Homerton NHS Trust and Hackney PCT, St Mary's Hospital and Westminster PCT; in addition to the Innovation institute and Department of Health presentations of progress against project plans.

As well as noting the progress to date, this report also gives a weighted risk rating noting a combination of the likelihood and impact of the failure of any individual

Work streams that have a number of inter-dependencies are mapped on a Gantt chart to ensure consistency with the master project plan. The aim is to update the project plan, and performance report monthly, the next iteration being for November 2007.

Project plans are reviewed weekly by the 18 week project management team, and key risks and areas requiring additional support and intervention discussed at the 18 week Steering Group Meeting that meets monthly and has PCT representation.

1.2.1 Review of Policies in line with 18 week rule changes

Two policies have been reviewed in line with the 18-week rule changes – the Scheduling Policy (formerly Admissions Policy) and the Trust DNA Policy. These were discussed in some detail at the Hospital Management Board and agreement has been reached with the overall direction of change for these policies.

1.2.2 Clearing the 18 week backlog

Last months demand assessment conducted by each of the divisions, has been matched with capacity planning this month. In total we have identified the requirements both to get to reduced access times for first and/or follow-up, and also to maintain them and hence the 18 week target

The current iteration attached (appendix 2) describes the number of additional lists and clinics required, above current activity, between October and the end of March 2008 that are required to clear backlog.

It is anticipated that equilibrium can be achieved for consistently hitting 18 weeks if the Imaging activity can be brought down from 13 to 4 weeks turn around for examination and results.

We have started to schedule the additional work to be undertaken, a proportion of which will need to be undertaken during evening and weekends. Remuneration arrangements for staff working additional hours has been agreed and approved by the Hospital Management Board.

1.2.4 Productivity Improvement

Planning for improvements in productivity are essential components in achievement of the 18-week target. Achieving the benefits associated with these plans allows the trust to demonstrate an efficient use of health economy recourses.

Theatre Productivity Plan

A productivity improvement plan has been devised and will be incorporated in to the 18-week project. Capacity benefits will facilitate the delivery of the 18-week target.

The work streams include: LOS; Theatre Staffing; Theatre Rota Management; Theatre Utilisation; Day Case Rates; Start Times and Cancellations; and a Pre Operative Assessment improvement plan.

Outpatient Productivity Plan

The work streams within this area include external demand measures, such as reducing consultant-to-consultant referrals and first to follow up ratios as well as internal methods such as making best use of current resources.

DNAs

One area requiring significant attention and improvement is DNAs.

Whittington DNA Rate:

- 06/07 Outpatient DNA rate **15.7%** or over **43,000** patients
- 07/08 rate remains at **15.6%**; 14.6% for new appointments and 16% for FUPs
- Based on average OPD tariff of £110 this equates to nearly **£350,000/mnth**
- Theatre DNA rate can vary between 2 and 12 per month at approximately **£500/patient.**

The plan is to reduce the overall number of DNAs by utilising telephone reminder systems, partial bookings, and improved patient communication.

Imaging Productivity Plan

Issues specific to imaging includes such work streams as Admin and Clerical Staff review; clinical establishment review; hot floor process redesign and review; management structure review; and, individual speciality redesign such as with Orthopaedic imaging services. The plan is listed in the Performance Report.

Linked Outpatient and Diagnostic test Appointments

One aspect of the work across Imaging and outpatients that will contribute both to productivity and to an improved patient experience is redesigning the pathway between patients' first outpatient appointment, on to imaging / diagnostics and back to outpatients for a follow-up appointment with a diagnostic report.

The objective is to design a one-stop booking service controlled against a standard wait for each patient.

There is a process-mapping meeting planned in November with the Imaging and outpatients team to confirm current processes and look to redesign.

1.2.5 Pathway Mapping

A considerable amount of work has been undertaken to map the path by which patients are referred and treated through the trust and its departments. We will continue to map pathways, with increased concentration on particular HRGs where waiting times are longer than others and at high volumes. Detailed work is also being undertaken for the pathways that cross between clinical departments and diagnostics - detailed in the productivity plans.

We are currently working with local PCTs to review and develop pathways across primary and secondary care.

1.2.6 Engagement with GPs / PCTs

The 18 week steering group, which includes representatives of Haringey and Islington

PCTs has agreed to develop a joint PCT / Trust heath economy 18 week plan. The group proposes transforming the primary care interface group to support this work.

The proposal is for the primary care interface group to adopt the 18 week target as its objective and to become a clinically led forum to plan and lead the implementation, particularly focussing on pathway changes and developments across primary and secondary care.

As part of this work each GM and project group will be asked to consider closer working with PCT and GP colleagues to develop demand managed pathways and direct access diagnostics that may include Service re-design for one stop shop solutions.

1.2.8 Physical Environment

It is essential to the success of the project that the current building work planned for the Hot Floor, K Block and Medical records space, Admissions and Appointments relocation and other Outpatient Department work are designed following review of the most efficient model for patient flow around these areas and functions. The physical design must be able to support achievement of the target, balanced with other operational imperatives

1.3 Next Steps

The following areas require clinical and managerial support and engagement in order to ensure that progress towards delivering the 18-week target is being made:

- Implementation of agreed policy changes.
- Greater clinical engagement in the completion of outcome forms, particularly completing DNAs and encouraging more junior staff to complete the forms.
- Planning at Divisional and Speciality level to start to reduce the Outpatient, Elective Inpatient, and Day Case Activity Backlog.
- Full implementation of the Productivity Plans for Outpatients Department, Theatres, and Imaging.
- Development of a health economy wide plan in consultation with the PCTs.

Appendices

1. Performance against 18 Weeks and Productivity Plan
2. 18 Week backlog Capacity Plan